

IMPROVING THE HEALTH CARE RESPONSE TO DOMESTIC VIOLENCE:

A RESOURCE MANUAL FOR HEALTH CARE PROVIDERS



AUTHORS

**Carole Warshaw, M.D.
Anne L. Ganley, Ph.D.**

EDITORS

**Debbie Lee
Nancy Durborow, M.A.
Patricia R. Salber, M.D., F.A.C.E.P.**

CONTRIBUTING AUTHOR

**Patricia R. Salber, M.D.,
F.A.C.E.P.**

CONTRIBUTING EDITORS

**Candace Heisler, J.D.
Patrick Letellier, M.A.
Barbara Hart, M.S.W., J.D.**

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FAMILY VIOLENCE PREVENTION FUND
383 RHODE ISLAND ST., SUITE 304
SAN FRANCISCO, CA 94103-5133
PHONE: (415)252-8900
FAX: (415)252-8991

DEDICATION

With the gift of listening comes the gift of healing, because listening to your brothers and sisters until they have said the last words in their hearts is healing and consoling. Someone once said that it is possible "to listen a person's soul into existence."

— Catherine de Hueck Doherty

We honor the many survivors of domestic violence who have taught us both about courage and survival. We thank them for their leadership.

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DEBBIE LEE
Associate Director
FAMILY VIOLENCE PREVENTION FUND
JUNE, 1995

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STAFF

FAMILY VIOLENCE PREVENTION FUND

Debbie Lee
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PENNSYLVANIA COALITION AGAINST DOMESTIC VIOLENCE

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Judy Yupcavage
Trish Patterson

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EMERGENCY DEPARTMENT DOMESTIC VIOLENCE PROGRAM

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Cindy Cutshall, RN
Linda Sowers
Karen Johnson, *Women In Need*
Lisa Johnson, *Women In Need*

PREFACE

HOW THIS MANUAL WAS DEVELOPED

BY DEBBIE LEE

This Resource Manual was produced by the Family Violence Prevention Fund (FUND) in collaboration with the Pennsylvania Coalition Against Domestic Violence (PCADV) as a component of the National Health Initiative on Domestic Violence funded by the Conrad N. Hilton Foundation.

The development of the Manual took place in four phases. During the first phase, hospital emergency department surveys were conducted in California, Pennsylvania, and nationally. The purpose was to collect baseline information on the existing emergency department response to domestic violence and to gauge the use of clinical protocols and training programs. Survey respondents were asked to send protocols, training curricula and educational materials to the FUND where they were analyzed and catalogued. Furthermore, ED respondents were asked if they would support the development of model resource and training materials on domestic violence. The materials gathered, baseline data collected and overwhelmingly positive directive to move forward with the production of a resource manual on domestic violence for health care providers concluded the first phase of this project.

Meanwhile, State Advisory Committees (SAC) were formed in both California and Pennsylvania to oversee the California and Pennsylvania State Health Initiatives on Domestic Violence. A National Advisory Committee (NAC) representing major medical and health associations and domestic violence coalitions was recruited to coordinate the FUND's National Health Initiative and guide its health-related program and policy activities. These influential committees made up of physicians, nurses, insurance and health care administrators, policymakers, batterer treatment providers, and medical social workers working in emergency department, ObGyn and primary care settings, as well as domestic violence experts, created the overall vision for the resource manual. In addition, the SACs coordinated the CA and PA emergency department surveys and also assisted with the design of the Model Emergency Department Domestic Violence Program and the selection of the twelve implementation sites. A 1993 NAC meeting in San Francisco and SAC meetings held in California and Pennsylvania laid the foundation for the substance and focus of the Resource Manual.

The second phase of development involved preparing a first draft of the Resource Manual for review by the NAC, clinical experts in the field and the hospitals participating in

the Model ED Domestic Violence Program. A December, 1994 meeting of the NAC involved a chapter-by-chapter review examining both content and format. In addition, national experts from a variety of health settings and disciplines reviewed the manual for its adaptability to a diversity of health care settings and applicability to the full spectrum of health care providers that would be using it.

During the third phase, the manual was evaluated for its "useability" through the six month Model ED Domestic Violence program in twelve CA and PA hospitals. Intensive two-day training sessions based on information contained in the manual were held in San Francisco, CA and Harrisburg, PA. The conferences were attended by multidisciplinary teams made up of an ED physician, nurse, social worker, administrator and community domestic violence expert from each of the twelve participating pilot test hospitals. The emergency department program evaluated the resource manual's content, gauged the effectiveness of its implementation strategies and tested the manual's adaptability to a variety of hospital settings.

The Resource Manual was then further revised and finalized based on feedback from the test-sites during the final phase of development. A team of skilled editors sifted through and incorporated the guidance received by national experts throughout the country. A comprehensive appendix was constructed using model materials collected and created to facilitate the ease of developing a health-facility-based domestic violence program. And finally, because so many voices were incorporated into the final document, a resource manual that is truly reflective of the diverse needs and circumstances of health care providers was developed.

Because of generous underwriting from the Conrad N. Hilton Foundation, as well as the U.S. Department of Health and Human Services, the Sierra Health Foundation, the William Randolph Hearst Foundation, and the Henry J. Kaiser Family Foundation, the FUND is able to make the Resource Manual available at cost.

We invite you to send us your thoughts and feedback regarding the manual and share with us any materials you think would be useful to further guide efforts to strengthen the health care response to domestic violence.



INTRODUCTION

BY PATRICIA R. SALBER, M.D.

Until recently, domestic violence was considered to be primarily a social or criminal-justice problem and therefore not in the purview of the health professional. Unfortunately, in many areas of the country, this attitude continues to prevail despite the fact that victims of domestic violence are routinely seeking care for medical complaints related to battering. Lacerations are sutured, broken bones are set, and emotional problems are medicated without an attempt to uncover or address their underlying cause. As a result, the medical community misses the opportunity to intervene in many hundreds of thousands of cases of domestic violence — and many, many victims continue to suffer the adverse health consequences of physical and emotional abuse.

The numbers are staggering. Close to 4 million American women are physically abused each year in this country (Straus,

Gelles & Steinmetz, 1980; *Violence Against Women*, 1990). Many of these women seek care in health care settings, often repeatedly (Berrios & Grady, 1991; Bowker & Maurer, 1987). One study conducted in an urban emergency department found that 24% of women seen for any reason had a history of domestic violence (Goldberg & Tomlanovich, 1984). Another study of injured women seen at an inner-city emergency department found that 30% of female trauma victims were injured due to battering. The number increased to 42% in the age range of 18-20 year-olds (McLeer & Anwar, 1989). Physical injuries due to battering can range from relatively minor bruising and abrasions to injuries requiring hospitalization, major surgical intervention, or death (Berrios & Grady, 1991; Federal Bureau of Investigation, 1993).

Emergency departments are not the only health care setting in which victims of domestic violence seek care. Twenty-eight percent of women surveyed in three university-affiliated ambulatory care internal medicine clinics had experienced domestic

The section on "Guiding Principles" (pages 4 to 6) was contributed by Anne L. Ganley, Ph.D.

IMPROVING THE HEALTH CARE RESPONSE

violence at some time in their lives; 14% were currently experiencing abuse (Gin, Rucker, Frayne, Cygan & Habbell, 1991). One Midwestern family practice clinic reported that 23% of women clients had been physically assaulted by their partners within the last year and 39% had experienced physical abuse at some time in their lives (Hamberger, Saunders & Hovey, 1992).

Obstetrical health providers have an especially important role in identifying battered women. Studies indicate that between 10-32% of women seeking care from prenatal health care providers have a past history of domestic abuse (Campbell, Poland, Waller & Ager, 1992; Helton, McFarlane & Anderson, 1987; Hillard, 1985; Parker, McFarlane, Soeken, Torres & Campbell, 1993; Stewart & Cecutti, 1993) and 4-8% of women are battered while pregnant (Amaro, 1990; Berenson, Stiglich, Wilkinson & Anderson, 1991; Campbell, et al., 1992; Helton, et al., 1987; Hillard, 1985; McFarlane, Parker, Soeken, & Bullock, 1992; Stewart & Cecutti, 1993). One recent study surveyed a sample of new mothers for a history of domestic violence in the 12 months preceding the birth of the index child — between 4-7% reported having been physically hurt by their husband or partner (Vandecastle, et al., 1994). Furthermore, battering during pregnancy jeopardizes the pregnancy. In one study of poor women, 24% of pregnant teens and 20% of pregnant adults entered prenatal care in the third trimester compared to 9% and 11% respectively of non-abused teens and adults (Parker, McFarlane, Soeken, Torres & Campbell, 1993). Abused women have a higher rate of miscarriage, stillbirths, premature labor, low birth weight babies, and injuries to the fetus, including fractures (Berrios & Grady, 1991; Bowker & Maurer, 1987; Bullock & McFarlane, 1989; Saltzman, 1990).

Mental health care providers see battered women for suicide attempts, anxiety and depression (American College of Obstetrics and Gynecology, 1989; Berrios & Grady, 1991; McGrath et al.,

1990; Stark & Flitcraft, 1988a). In one study, 64% of female psychiatric inpatients experienced physical assaults and 38% experienced sexual assaults as adults; these were largely due to abusive relationships (Jacobson & Richardson, 1987).

Orthopedists, orthopedic nurse practitioners and physician assistants see battered women with fractures and other musculoskeletal complaints caused by domestic violence. These women seek care from specialists in "head and neck" medicine for perforated eardrums, nasal fractures, dislocated mandibles, and septal hematomata. Dentists see battered women with fractured teeth, "bad bites," and broken jaws. Ophthalmologists and other eye care professionals see battered women with subconjunctival hematomata, retinal detachments, orbital blow-out fractures and lid lacerations. Practitioners who specialize in chronic pain syndromes, such as headache, chronic pelvic pain or functional gastrointestinal disorders, also see battered women (Domino & Haber, 1987; Drossman et al., 1990; Follingstad et al., 1991; Haber & Roos, 1985). Some HIV-positive women or women with AIDS may have contracted the virus from coerced sexual activity in the context of a battering relationship (Zierler et al., 1991). Health care providers who see abused children also see battered women because child abuse and spousal abuse frequently co-exist (Bowker & Maurer, 1987; McKibben, DeVos & Newberger, 1989; Stark & Flitcraft, 1988b; Walker, 1979).

Battered women have a decreased subjective sense of their physical and mental well-being, an increase in reported symptoms across a wide variety of organ systems, particularly gynecologic symptoms, and an increased utilization of medical resources (Follingstad et al., 1991; Jaffe, Wolfe, Wilson & Zak, 1986; Kerouac, Taggart, Lescop & Fortin, 1986; Koss, Koss & Woodruff, 1991; Rodriguez, 1989). In one study, the frequency of abuse was a strong predictor of the number and severity of reported symptoms (Follingstad et al., 1991).

Battered women also have a higher incidence of injurious health behaviors such as smoking, drug and/or alcohol abuse, and poor dietary habits (Amaro, 1990; Koss, Koss & Woodruff, 1991; Rodriguez, 1989; Root & Fallon, 1988; Stewart & Cecutti, 1993).

While the research cited above refers to the tremendous impact of battering on heterosexual women, domestic violence is not an exclusively heterosexual phenomenon. Lesbians and gay men also suffer the adverse consequences of abuse in their relationships, and present with injuries and trauma in many of the same medical settings as heterosexual battered women. The few studies that have been conducted on lesbian battering indicate that it happens at approximately the same rate as heterosexual battering (Renzetti, 1992). In the absence of empirical research on gay male battering, we must look to anecdotal evidence and expert opinion, both of which indicate battering as a serious and widespread problem among gay men (Letellier, 1994).

Although it is difficult to know the true dollar costs for providing direct medical care to victims of domestic violence, it is estimated to be in the range of \$1.8 billion per year (Miller, Cohen & Wiersema, 1995). When other factors are added in, such as days of work missed, decreased productivity at the workplace due to emotional, psychiatric and medical sequelae of abuse, and loss of young individuals from the workforce due to early death or disability, the financial toll is huge.

Despite the fact that health practitioners see many victims of domestic violence in their clinical practices and despite the fact that the impact on the health care system is enormous, many health professionals fail to recognize the problem because they don't routinely inquire about or document abuse as the cause of their patient's symptoms (Friedman, Samet, Roberts, Hulin & Hans, 1992; Goldberg & Tomlanovich, 1984; Hamberger et al., 1992; Helton et al., 1987; Kurz, 1987; McLeer & Anwar, 1989; Morrison, 1988;

Stark, Flitcraft & Frazier, 1979; Warshaw, 1989). This failure occurs even though many physicians believe questions about physical and sexual assault should be asked routinely (Friedman et al., 1992). Furthermore, studies document that most patients want health care providers to ask about abuse and would answer truthfully if asked (Friedman et al., 1992; Rounsaville & Weisimann, 1978).

The reasons why health professionals have failed to appropriately respond to victims of domestic violence are myriad and complex, but crucial to understand if we are going to improve the response of the health care system to domestic violence. A thorough discussion of the barriers to identification of domestic violence victimization can be found in Chapter Two. Briefly, they include a lack of training about domestic violence (Holtz, Hanes & Safran, 1989); providers' misconceptions about who is affected by domestic violence, biases and/or prejudices (Burge, 1989; Kramer, 1993; Langford, 1990); and current or prior experiences with domestic violence outside of the health care setting (Sugg & Inui, 1992; Warshaw, 1993). Health professionals may not want to inquire about domestic violence because of the fear of opening a "Pandora's box" and/or because of concerns about time constraints (Sugg & Inui, 1992; Warshaw, 1993). Some may not inquire because of concerns about privacy (Jecker, 1993; Kurz & Stark, 1988; Sugg, 1992) and/or confidentiality — especially in states where mandatory reporting laws exist.¹ Others may feel that inquiry and intervention are not appropriate roles for them and should be the responsibility of social workers and mental health professionals. Still others may become frustrated with battered individuals who are "difficult" or intoxicated or have vague but recurring and seemingly undiagnosable symptoms that lead the professional to

¹See Appendix N for a full discussion of the implications of mandatory reporting of domestic abuse by health professionals.

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apply labels such as "crock," "hysteric," "somatization disorder," or "self-defeating personality disorder" to the patient (Stark et al., 1979).

Health providers, however, are uniquely situated to be effective in helping reduce the tragedy of domestic violence. As already described, they frequently encounter battered women in their clinical practices. The special nature of the provider-patient relationship offers a unique opportunity to intervene in this serious problem.

To be effective in combatting domestic violence, however, professionals must rethink the traditional medical approach. They must develop a fuller understanding of the effect of all of the circumstances of an individual's life on his/her health. This requires the consideration of social conditions, such as domestic violence, when trying to determine the etiology of a patient's symptoms. It also mandates a consideration of therapeutic options beyond prescriptions, such as giving patients messages like "There is help available," and "You don't deserve to be beaten." It involves giving victims information which can help them confront and, hopefully, eliminate the violence in their lives.

Individual personal health practitioners must move closer to the practice of traditional public health providers by studying the health of the populations they serve and designing population-based strategies which ameliorate the adverse health consequences of identified factors. It is only by utilizing such strategies that health professionals can begin to be truly effective in illness prevention and health promotion.

In the area of domestic violence, this means helping to make the health care system more responsive to victims of domestic violence. There are a variety of ways in which individual practitioners can make a difference, including educating colleagues, implementing domestic violence protocols, setting up hospital-based advocacy programs, and establishing interdisciplinary domestic violence committees.

It is also crucial that health care providers work with local domestic violence experts. They have been at the helm of the domestic violence field — carrying out community education and prevention activities, educating law enforcement, prosecutors, the judiciary and elected officials, as well as health care providers. Domestic violence programs have shaped laws at local, state and national levels protecting battered women and their children.

Since the mid 1970's, community groups and formerly battered women have responded to the needs of battered women by establishing over 1,200 domestic violence programs throughout this country. The keystone of domestic violence services has been safe shelter for battered women and their children. While shelter is only a temporary stop-gap, it is a life saving one. However, as public education and awareness has grown, the supply of shelter beds has been unable to keep up with the demand, which can sometimes leave victims and providers frustrated.

Many other services are an integral part of the empowerment and advocacy offered by domestic violence programs. These include: crisis counseling, legal advocacy, job training, assistance with welfare and housing, counseling for children, relocation assistance, bilingual services and a variety of other services. This comprehensive approach to service delivery is unique among human services programs. It is important for the health care community to become familiar with the domestic violence program(s) in their own communities. Collaboration with domestic violence programs can result in developing more appropriate services to victims of domestic violence and their families.

Effective domestic violence prevention also requires going beyond the clinical setting and out into the community where the roots of violence are pervasive. Health professionals can provide leadership in domestic violence prevention by participating in public education, victim advocacy, and political action. The role of the health

provider in health systems and community change is discussed in detail in Chapter 4.

This manual was developed to give physicians, nurses, medical social workers and other health care personnel a wide range of information and other tools, including model protocols, patient education materials, practitioner guides and resource information, necessary for becoming more effective in domestic violence identification, intervention and prevention. The authors of this manual believe that all health care providers should be guided by certain principles when designing and implementing strategies for improving responses to victims of domestic violence. These principles are:

This approach, however, is at odds with the second principle outlined above — respect for victims' integrity and authority over their lives. Providers must understand that, unlike child abuse cases where the victims are vulnerable children, the victims of domestic violence are adults who have a right to make their own decisions. Victims almost always know far more about themselves and their abusers than the health care providers do. This knowledge helps the victim formulate a response to the violence. The health care provider can play an important role in the victim's decision-making process by asking the right questions, providing information about the nature of domestic violence, giving

GUIDING PRINCIPLES

1. Regarding safety of victims and their children as a priority.
2. Respecting the integrity and authority of each battered woman over her own life choices.
3. Holding perpetrators responsible for the abuse and for stopping it.
4. Advocating on behalf of victims of domestic violence and their children.
5. Acknowledging the need to make changes in the health care system to improve the health care response to domestic violence.

It almost goes without saying that safety for victims and their children is a top priority in any health care intervention. Once health professionals understand the serious health risks posed by domestic violence, they are usually aggressive in their response (e.g., "I will save her life by making her to go to the shelter right now").

messages of support, and letting her know about resources in the health care setting and in the community which can provide an alternative to the violence. At times it will be appropriate for the health care provider to make recommendations about what to do, but only after understanding the full reality of the victim's situation and

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with the understanding that, ultimately, the victim must make her own choices.

Respecting victims' authority over their own lives is important for another reason. At the core of domestic abuse is the batterer's desire to control the victim's life, including her ability to make decisions for herself. When health care providers insist that victims obey their "prescription" to leave their abusers and go to a shelter immediately, they reinforce their lack of self-determination and victimize them further. Providers need to understand that the decision to leave — or stay — is the victim's to make and theirs to respect.

There are ambiguities and tensions involved in developing responses which are in keeping with both the safety and autonomy principles. Some providers may give more weight to the safety principle and be influenced by a desire to "protect" the patient and therefore demand that she leave the situation or go to a shelter. Other providers may place greater emphasis on the principle of self-determination and therefore fail to help the patient develop a safety plan because of an erroneous belief that the patient could just leave the situation in order to protect herself. This manual will help readers develop strategies that recognize and incorporate both principles into their response to domestic violence.

The purpose of the third principle is to hold the perpetrator, not the victim, responsible for the abuse. Abusers alone determine when, where, why and toward whom they will be violent. This is important to keep in mind whether the health provider's contact is with a victim or a perpetrator. Health professionals can avoid overt or covert victim-blaming by remembering that, no matter what the circumstances, there is no excuse for domestic violence.

Holding perpetrators responsible for domestic abuse is not solely the responsibility of the criminal justice system. Health professionals can hold perpetrators responsible in a number of ways. They can refuse to continue in silent collusion with batter-

ers and start to accurately name the problem of domestic violence. They can tell victims that they do not deserve abusive treatment. They can cut through abusers' minimization, denial, rationalization, and blaming to insist that it is the abuser's responsibility, not the victim's, to stop his abusive behaviors.

The fourth and fifth principles, commitments to provide advocacy and to improve the health care system's ability to respond to victims of domestic violence, require fundamental changes in the ways that health providers approach domestic violence. They require changes in individual practice patterns and changes in institutional structures. They also require "institutionalization" of these changes. Moreover, a truly effective response requires an interdisciplinary approach involving physicians, nurses, social workers, health educators and other allied health personnel.

In the realm of individual practice changes, providers must become more aware of domestic violence, begin to actively and routinely inquire about abuse, and have the knowledge and skills to assess safety and refer appropriately. It is equally important that they understand and embrace the concept of advocacy as a crucial health care response. Advocacy includes activities which take place in the health care setting (e.g., involving the victims in the decision-making process, providing knowledge and support as the patient goes through the medical encounter, and working to make the health care system more responsive to victims of domestic violence). It also involves activities which go beyond the health care setting and into the community, such as involvement with the local shelter, community education about domestic violence, and the formation of domestic violence consortia to coordinate otherwise fragmented services and to share resources (Langford, 1990). Advocacy means political activities such as involvement in organized medicine, nursing or other professional organizations. It also means active involvement in

shaping legislation and regulations which affect battered women and their children (Salber & Taliaferro, 1995; Sheridan, 1987). The need for these changes and model intervention strategies are described in more detail in Chapter 4.

These guiding principles form the heart of this manual. They are woven into the text and content of every chapter. The authors hope this manual will serve as the beginning of your education about domestic violence. Wherever possible, we have provided references and resources to further your knowledge about this crucial issue which so profoundly affects the health and well-being of so many of our patients. We also hope that you will use this educational experience to change the

way you view your role and responsibility to victims of domestic abuse. It is no longer acceptable to say that this is the role of some other type of service provider. It is everyone's responsibility. For that reason, we believe that you have an obligation to educate your peers about their role in domestic violence identification and intervention and help improve your practice's ability to respond to domestic violence. Therefore, we encourage you to share this manual with others and to freely utilize the resource materials contained in it. We hope you will become a teacher, an advocate, and a leader in the movement to improve the health care response to victims of domestic violence.

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CHAPTER 1

UNDERSTANDING DOMESTIC VIOLENCE

BY ANNE L. GANLEY, PH.D.



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INTRODUCTION: THE HEALTH IMPACT OF DOMESTIC VIOLENCE

Domestic violence is a problem of epidemic proportions with far-reaching consequences for individual victims, their children and their communities. Domestic violence results in death, serious injury, and chronic medical and mental health issues for victims, their children, the perpetrators, and others. The lethal outcome of domestic violence is tragically evident in media reports that describe a steady stream of homicides against victims, their children, family or friends, those who are trying to protect them, innocent bystanders, and perpetrators.

Discussing what is known about homicides and suicides is only one way to understand the lethal nature of domestic violence. At this time there is little research measuring the impact of assaults and abuse in terms of permanent and health-shatter-

ing injuries and illnesses. For every homicide victim of domestic violence, there are many victims struggling with major health problems who did not die when shot, stabbed, clubbed, burned, choked, beaten or thrown by their abusers. Thousands of these victims struggle with the health consequences of being trapped in abusive relationships without being identified by health care providers or provided with proper treatment (Hamberger, Saunders & Honey, 1992).

Domestic violence presents unique challenges to the health care system and requires specialized responses from health care providers. Before providers are able to effectively and efficiently respond to patients experiencing domestic violence they must first understand the nature and etiology of the problem as well as its impact

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on victims, children, and the community as a whole. This chapter provides the framework for that understanding by reviewing

the definition and causes of domestic violence as well as specific issues related to victims, perpetrators, and children.

I. DEFINITION OF DOMESTIC VIOLENCE

Domestic violence has many names: wife abuse, marital assault, woman battery, spouse abuse, wife beating, conjugal violence, intimate violence, battering, partner abuse, for example. Sometimes these terms are used interchangeably to refer to the problem, while at other times a particular term is used to reflect a specific

meaning (e.g., “woman abuse” to highlight the fact that most victims are women). In addition to these multiple terms, there are different behavioral and legal definitions for domestic violence. With so many varying terms and definitions, there can be a lack of clarity about what is meant by domestic violence, leading to inconsisten-

FIGURE 1-1

DEFINITION OF DOMESTIC VIOLENCE

Domestic violence is a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners.

Key elements of domestic violence:

1. Conduct perpetrated by adults or adolescents against their intimate partners in current or former dating, married or cohabiting relationships of heterosexuals, gay men, and lesbians.
2. A pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks as well as economic coercion.
3. A pattern of behaviors including a variety of tactics — some physically injurious and some not, some criminal and some not — carried out in multiple, sometimes daily episodes.
4. A combination of physical attacks, terrorist acts, and controlling tactics used by perpetrators that result in fear as well as physical and psychological harm to victims and their children.
5. A pattern of purposeful behavior, directed at achieving compliance from or control over the victim.

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cies in identification, assessment, and interventions as well as inconsistencies in research.

For the purpose of this manual, a behavioral definition of domestic violence is used rather than a legal definition, since a behavioral definition is more comprehensive and more relevant to the health care setting.¹ (See Figure 1-1) Domestic violence is herein defined by (1) the relationship context of the violence, (2) the perpetrator's behaviors, and (3) the function those behaviors serve. Throughout this manual, the terms "domestic violence," "abuse," and "battering" will be used interchangeably.

A. Relationship Context

Domestic violence occurs in a relationship where the perpetrator and victim are known to each other. It occurs in both adult and adolescent intimate relationships. The victim and perpetrator may be dating, cohabiting, married, divorced, or separated. They are heterosexual, gay or lesbian.² They may have children in common. The relationships may be of short or long duration.

The intimate context of the violence is important in understanding the nature of the problem and in developing effective interventions. To an outside observer, domestic violence may look like stranger-to-stranger violence (e.g., punching, slapping, kicking, choking). Domestic violence victims experience traumas similar to those of victims of stranger violence (e.g., burns, internal injuries, head injuries, bruises, stab wounds, broken bones, muscle damage, psychological trauma). However, the intimate context of domestic violence shapes the way in which both the

perpetrator and the victim relate to and are affected by the violence. And, unfortunately, the intimate context all too often leads those outside the relationship to take domestic violence less seriously than other types of violence.

In domestic violence, perpetrators have on-going access to their victims, know their daily routines and vulnerabilities, and can continue after violent episodes to exercise considerable physical and emotional control over their daily lives. In addition, these perpetrators have knowledge of their victims (e.g., prior medical conditions, allegiance to their children) which they use to target their assaults (e.g., withholding medications, grabbing victims from behind, threatening to harm the children), increasing the victims' trauma and fear.

Victims of domestic violence not only deal with the particularities of a specific trauma (e.g., head injury) and the fear of future assaults by a known assailant, but must also deal with the complexities of an intimate relationship with that assailant. Many perpetrators believe that they are entitled to use tactics of control with their partners and too often find social supports for those beliefs. It is the "family" nature of these relationships that sometimes gives the perpetrator social, if not legal, permission

¹ Health care providers may want to become familiar with the legal definition of domestic violence in their jurisdiction and note the similarities and differences in the ways domestic violence is defined.

² For the purposes of this manual, masculine pronouns are generally used when referring to perpetrators of domestic violence, while feminine pronouns are generally used to reference victims. This is not meant to detract from those cases where the victim is male or the perpetrator is female. This pronoun usage reflects the fact that the majority of domestic violence victims are female. The U.S. Department of Justice estimates that 95% of reported assaults on spouses or ex-spouses are committed by men against women (Douglas, 1991). There are no prevalence figures for domestic violence in gay and lesbian relationships, but experts (Lobel, 1986; Renzetti, 1992; Letellier, 1994) indicate that domestic violence is a significant problem in same-sex relationships as well. Consequently, some of the examples in the manual are specific to gay, lesbian or heterosexual relationships, while others apply to all three.

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to use abuse. Unlike victims of stranger violence, victims of domestic violence face social barriers to a separation from their perpetrators as well as barriers to other strategies for self protection (Hart, 1993).

Domestic violence as defined here does not include other types of intimate or family violence: child abuse/neglect, child-to-parent violence, sibling violence, and the abuse of the elderly (unless the abuse is being perpetrated by the elder's intimate partner). While other types of family violence may result in the same kinds of physical injuries and psychological damage found in domestic violence cases, the dynamics are different, require different interventions, and are beyond the scope of this manual.

B. Domestic Violence: A Pattern of Behaviors

Domestic violence is not an isolated, individual event, but rather a pattern of perpetrator behaviors used against a victim. The pattern consists of a variety of abusive acts, occurring in multiple episodes over the course of the relationship. Some episodes consist of a sustained attack with one tactic repeated many times (e.g., punching), combined with a variety of other tactics (such as name calling, threats, or attacks against property). Other episodes consist of a single act (e.g., a slap, a "certain look"). One tactic (e.g., physical assault) may be used infrequently, while other types of abuse (such as name calling or intimidating gestures) may be used daily. Battering episodes last a few minutes to several hours or days. While some perpetrators repeat a particular set of abusive acts, other perpetrators use a wide variety of tactics with no particular routine.

Each episode of domestic violence is connected to the others. One battering episode builds on past episodes and sets the stage for future episodes. Perpetrators refer to past episodes (e.g., "Remember the last time?") and make threats about future

abuse as a way to maintain control. Batterers use a wide range of coercive behaviors that result in a wide range of consequences, some physically injurious and some not, but all psychologically damaging. Some parts of the pattern are crimes in most states (e.g., physical assault, sexual assault, menacing, arson, kidnapping, harassment) while other battering acts are not illegal (e.g., name calling, interrogating children, denying the victim access to the family automobile). All parts of the pattern interact with each other and can have profound physical and emotional effects on victims. Victims respond to the entire pattern of perpetrators' abuse rather than simply to one episode or one tactic. While a health care provider may be attempting to make sense of one incident that resulted in an injury, the victim is dealing with that single episode in the context of all the other obvious and subtle episodes of abuse.

The abusive and coercive behaviors take different forms: physical, sexual, psychological, and economic. To understand the pattern, different types of domestic violence behaviors are described below. The first two categories are types of physically assaultive battering where the perpetrator has direct contact with the victim's body. The other categories involve tactics where the perpetrator has no direct physical contact with the victim's body during the attack although the victim is clearly the target of the abuse.

1. PHYSICAL ASSAULTS

Physical abuse may include spitting, scratching, biting, grabbing, shaking, shoving, pushing, restraining, throwing, twisting, slapping (with open or closed hand), punching, choking, burning, and/or use of weapons (e.g., household objects, knives, guns) against the victim. The physical assaults may or may not cause injuries. Sometimes a seemingly less serious type of physical abuse, such as a shove or push, can result in the most serious injury. The perpetrator may push the victim against a couch,

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a wall, down a flight of stairs, or out of a moving car, all of which could result in varying degrees of trauma (e.g., bruising, broken bones, spinal cord injuries). Sometimes the physical abuse does not cause a specific injury but does cause other health problems. For example, one perpetrator frequently abused his partner during meals and late at night. He would push, restrain, and spit at his partner as well as abuse her verbally. While there were no visible injuries, the victim suffered from severe sleep deprivation and poor nutrition, since both her sleep and eating patterns were repeatedly interrupted by her abuser's conduct.

2. SEXUAL ASSAULTS

Some perpetrators sexually batter their victims. Sexual battering consists of a wide range of conduct that may include pressured sex when the victim does not want sex, coerced sex by manipulation or threat, physically forced sex, or sexual assault accompanied by violence. Victims may be coerced or forced to perform a kind of sex they do not want (e.g., sex with third parties, physically painful sex, sexual activity they find offensive, verbal degradation during sex, viewing sexually violent material) or at a time they do not want it (e.g., when exhausted, when ill, in front of children, after a physical assault, when asleep). Some perpetrators attack their victims' genitals with blows or weapons. Some perpetrators deny victims contraception or protection against sexually transmitted diseases. The perpetrators' message to the victims is that they have no say over their own bodies. Sometimes victims will resist and are then punished, and sometimes they comply in hopes that the sexual abuse will end quickly. For some battered victims this sexual violation is profound and may be difficult to discuss. Some victims are unsure whether this sexual behavior is really abuse, while others see it as the ultimate betrayal.

3. PSYCHOLOGICAL ASSAULTS

There are different types of psychological assaults.

a. Threats of violence and harm

The perpetrator's threats of violence or harm may be directed against the victim or others important to the victim or they may be suicide threats. Sometimes the threat includes killing the victim and others and then committing suicide. The threats may be made directly with words (e.g., "I'm going to kill you," "No one is going to have you," "Your mother is going to pay," "I cannot live without you") or with actions (e.g., stalking, displaying weapons, hostage taking, suicide attempts). Perpetrators may be violent towards others (e.g., neighbors, family members) as a means of terrorizing victims. Perpetrators may coerce victims into doing something illegal (e.g., prostitution, larceny) and then threaten to expose them, or may make false accusations against them (e.g., reports to Child Protective Services, to the welfare department, or to immigration).

b. Attacks against property or pets and other acts of intimidation.

Attacks against property and pets are not random acts. It is the wall the victim is standing near that gets hit, or the door she is hiding behind that gets torn off of its hinges, the victim's favorite china that is smashed or her pet cat that is strangled in front of her, the table that she is sitting near that gets pounded or one of the perpetrator's favorite objects that gets smashed while he says, "Look what you made me do." The message to the victim is always, "You can be next."

The intimidation can also be carried out without damage to property, by the perpetrator yelling and screaming in the victim's face, standing over the victim during a fight, driving recklessly when the victim or children are present, stalking, or putting the victim under surveillance. The

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intimidation may not always include a threat of physical harm, but may instead be carried out by damaging the victim's relationships with others or her reputation in her community by discrediting her with employers, ministers, friends, neighbors.

c. Emotional abuse

Emotional abuse is a tactic of control that consists of a wide variety of verbal attacks and humiliations, including repeated verbal attacks against the victim's worth as an individual or role as a parent, family member, friend, co-worker, or community member. The verbal attacks often emphasize the victim's vulnerabilities (such as her past history as an incest victim, language abilities, skills as a parent, religious beliefs, sexual orientation, or HIV status).

Sometimes the batterer will play "mind games" to undercut the victim's sense of reality (e.g., specifically directing her to do something, then claiming that he never asked her to do it when she complies). Sometimes emotional abuse consists of forcing the victim to do degrading things (e.g., going to the perpetrator's mistress' home to retrieve her children, getting on her knees and using a toothbrush to clean up food the perpetrator smeared on the kitchen floor, or going against her own moral standards). Emotional abuse may also include humiliating the victim in front of family, friends or strangers. Perpetrators may repeatedly claim that victims are crazy, incompetent, and unable "to do anything right." These tactics of abuse are similar to those used against prisoners of war or hostages and they are used for the same purpose: to maintain the perpetrator's power and control.

Emotional abuse in domestic violence cases is not merely a matter of someone getting angry and calling his partner a few names or cursing. Not all verbal insults between partners are acts of violence. In order for verbal abuse to be considered domestic violence, it must be part of a pattern of coercive behaviors in which the

perpetrator uses or threatens to use physical force. In domestic violence, verbal attacks and other tactics of control are intertwined with the threat of harm in order to maintain the perpetrator's dominance through fear. While repeated verbal abuse is damaging to partners and relationships over time, it alone does not establish the same climate of fear as verbal abuse combined with the use or threat of physical harm.

The presence of emotionally abusive acts may indicate undisclosed use of physical force or it may indicate possible future domestic violence. There is no way at this time in domestic violence research to predict which emotionally abusive relationships will become violent and which will never progress beyond verbal abuse. If the victim feels abused or controlled or afraid of her partner without showing or offering clear descriptions of physical harm, then the cautious approach would be to accept the patient's views as stated and to respond with concerns about the victim's safety and psychological well-being.

d. Isolation

Perpetrators often try to control victims' time, activities and contact with others. They gain control over them through a combination of isolating and disinformation tactics. Isolating tactics may become more overtly abusive over time. At first perpetrators cut victims off from supportive relationships by claims of loving them "so much" and wanting to be with them all the time. In response to these statements, victims may initially spend increasing amounts of time with their perpetrators. These subtle means of isolating the victim are then replaced with more overt verbal abuse (e.g., complaints about "interfering" family or "dykey" looking friends, complaints about her spending too much time with others); sometimes the perpetrator uses physical assaults or threats of assault to separate the victim from her family or friends. He may lock her out of her house or control her movements by

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taking her car keys or forcing her to quit her job. Through incremental isolation, some perpetrators increase their psychological control to the point where they determine reality for the victims.

Perpetrators' use of disinformation tactics such as distorting what is real through lying, providing contradictory information, or withholding information is compounded by the forced isolation of the victims. For example, perpetrators may lie to victims about their legal rights or the outcomes of medical interventions. While many victims are able to maintain their independent thoughts and actions, others believe what the perpetrators say because the victims are isolated from contrary information. Through his victim's isolation, the perpetrator prevents discovery of the abuse and avoids being held responsible for it.

The perpetrator isolates the victim by acting jealous and interrupting social/support networks. Some perpetrators act very possessive about their victims' time and attention. They often accuse them of sexual infidelity and of other supposed infidelities, such as spending too much time with children, the extended family, at work, or with friends. They claim that family or friends are trying to ruin their relationship. This jealousy about alleged lovers, friends, or family is a tactic of control.

e. Use of children

Some abusive acts are directed against or involve the children in order to control or punish the adult victim (e.g., physical attacks against a child, sexual use of the children, forcing children to watch the abuse of the victim, engaging children in the abuse of the victim). A perpetrator may use children to maintain control over his partner by not paying child support, requiring the children to spy, requiring that at least one child always be in the company of the victim, threatening to take children away from her, involving her in long legal fights over custody, or kidnapping or

taking the children hostage as a way to force the victim's compliance.

Children are also drawn into the assaults and are sometimes injured simply because they are present (e.g., the victim is holding an infant when pushed against the wall) or because the child attempts to intervene in the fight. The perpetrator's visitations with the children are used as opportunities to monitor or control the victim. These visitations become nightmares for the children as they are interrogated about the victim's daily life. (For further discussion see Section III. C. of this chapter.)

4. USE OF ECONOMICS

Perpetrators control victims by controlling their access to all of the family resources: time, transportation, food, clothing, shelter, insurance, and money. It does not matter who the primary provider is or if both partners contribute. The perpetrator is the one who controls how the finances are spent. He may actively resist the victim becoming financially self-sufficient as a way to maintain power and control. Conversely, he may refuse to work and insist that she support the family. He may expect her to be the family "book-keeper," requiring that she keep all records and write all checks, or he may keep financial information away from her. In all instances he alone makes the decisions. Victims are put in the position of having to get "permission" to spend money on basic family needs.

When the victim leaves the battering relationship, the perpetrator may use economics as a way to maintain control or force her to return: refusing to pay bills, instituting legal procedures costly to the victim, destroying assets in which she has a share, or refusing to work "on the books" where there would be legal access to his income. All of these tactics may be used regardless of the economic class of the family.

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5. THE CONNECTION BETWEEN VIOLENCE AND OTHER TACTICS OF CONTROL

It is the perpetrators' use of physical and sexual force or threats to harm person or property that gives power to their psychologically abusive acts. Psychological battering becomes an effective weapon in controlling victims because they know from experience that perpetrators will at times back up their threats or taunts with physical assaults. Sometimes the perpetrator uses physical force infrequently, with no discernible pattern. However, even when the assault only happens once or ends without injury, that incident establishes the threat of violence. If the perpetrator has been violent against someone else (e.g., a previous intimate partner, in war, on the street), reference to that history can also establish the threat of violence against the victim. The fact that the perpetrator has used violence in the past to get what he wants gives him power over her by instilling fear and conveying a promise of violence absent her compliance.

Perpetrators will use that fear to coercively control their victims through other, non-physical tactics. Sometimes perpetrators are able to gain compliance from the victim by simply saying, "Remember what happened the last time you tried to get a job?", referring to a time when the perpetrator assaulted the victim for getting "the wrong kind of job." Because of the past use of physical force, there is an implied threat in the statement and the victim becomes reluctant to pursue a job against the perpetrator's wishes. Sometimes the perpetrator will refer to his violence against others (e.g., "You know, I was a trained killer in the military," "You're acting like Susie and you know what happened to her") or sometimes use more overt threats to kill or maim the victim or others.

Psychological control through intermittent use of physical assault along with psychological abuse is typical of domestic

violence and is the same control tactic used against hostages or prisoners of war (Graham & Rawlings, 1991; Ganley, 1981). Sometimes physical abuse, threats of harm, and isolation tactics are interwoven with seemingly loving gestures (e.g., expensive gifts, intense displays of devotion, sending flowers after an assault, making romantic promises, tearfully promising it will never happen again). Amnesty International (1973) describes such "occasional indulgences" as a method of coercion used in torture. With such tactics, the perpetrator provides positive motivation for victim compliance. The perpetrator is able to control the victim through this combination of physical and psychological tactics since the perpetrator connects the threat of physical harm so closely with the psychological tactics. The message is always there that if the victim does not respond to this "loving" gesture or verbal abuse, then the perpetrator will escalate and use whichever tactic, including force, is necessary to get what he wants.

6. THE RESEARCH ON MUTUAL BATTERING

Some mistakenly believe that both the perpetrator and the victim are abusive, one physically and one verbally. One research study indicates that domestic violence perpetrators are more (rather than less) verbally abusive than their victims, other persons in distressed/non-violent relationships or persons in non-distressed intimate relationships (Margolin, Gleberman, John, & Ransford, 1987). Another study found that while both battering men and battered women use verbal aggression, only the battering men combined their verbal aggression with acts of violence to control their partners (Jacobson et al. 1994). Even if both use verbal aggression, the reality is that a verbal insult is not the same as a fist to the face. Verbal and physical aggression do not have the same power to cause physical

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harm and terror.

Some argue that there is "mutual battering" where both individuals use physical force against each other. In such cases careful assessment often reveals that one partner is the primary physical aggressor while the other attempts to defend herself or protect her children (e.g., she stabbed him as he was choking her) or that the perpetrator's violence is more severe (e.g., his punching/choking versus her scratching) (Saunders, 1986; Hamberger & Potente, 1994). Research of heterosexual couples indicates that women's motivation for using physical force is self-defense while men use force for power and control (Saunders & Browne, 1991; Wilson & Daly, 1992; Jacobson et al., 1994). "Mutual combat" among gay and lesbian partners is also rare. Even though gay and lesbian partners may be approximately the same size and weight, there is usually a primary aggressor who is creating the atmosphere of fear and intimidation that characterizes abusive relationships (Letellier, 1994; Lobel, 1986; Renzetti, 1992). Self-defense against an abusive partner does not constitute "mutual battering." Moreover, what perpetrators report as abusive behavior against themselves are often acts of resistance to the abuse. Victims engage in survival strategies during which they sometimes resist the demands and coercive control of the perpetrators. (See Section III. A.) Perpetrators respond to such resistance with escalating tactics of control and violence.

7. CHANGES IN THE PERPETRATOR'S ABUSIVE PATTERN

A perpetrator's pattern of abusive behaviors may change. Sometimes the perpetrator uses more psychological tactics and at other times more physical tactics. There is no evidence that domestic violence progresses in a linear fashion from verbal insults to minor assaults to homicide. Some perpetrators' physical violence

escalates, while for others the use of physical force stabilizes or even decreases as their use of other tactics increases. Perpetrators change tactics and use the tactics that are most useful in gaining control. There is no evidence that a perpetrator's abusive behavior simply stops on its own. Even in the research where the use of physical force seems to have stopped for a period of time (Hamberger & Hastings, 1990; Sheppard, 1988; Jacobson, et al., 1995), it is unclear whether the perpetrators have merely switched to non-physical tactics of control and whether the cessation of physical force will be permanent. Changes in the pattern do not necessarily mean the end of the abusive conduct.

C. DOMESTIC VIOLENCE: PURPOSEFUL, COERCIVE BEHAVIOR

Domestic violence is purposeful and instrumental behavior. The abuse is directed at achieving compliance from or control over the victim. The pattern is not random or "out of control" behavior. Perpetrators who minimize or excuse their behavior by claiming they "lost it" or "were out of control" have actually made specific choices. Perpetrators follow their own internal set of rules and regulations for their use of abusive behaviors. Some will batter only in particular ways (e.g., hit certain parts of the body). Others use violence only toward their victims even though they may be in conflict with their boss, other family members, or the health care provider. Some will hit only in private, while others hit in public. Some will break only the victim's possessions and not their own while others will not engage in any property destruction. Such decision-making indicates that they are actually in control of their abusive behaviors. (Ganley, 1981, 1991; Adams, 1989).

Domestic violence involves a pattern of behavior and certain tactics require a great

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deal of planning to execute (e.g., stalking, interrogating family members). Some batterers impose rules on the victims (Fischer, Vidmar, & Ellis, 1993), carefully monitoring their compliance and punishing them for any "infractions" of the imposed rules. Such attention to detail contradicts the notion that perpetrators "lost" control or that their abusive conduct is the result of poor impulse control.

Interviews with perpetrators reveal that when using both overt and subtle forms of abuse, perpetrators know what they want from victims (Ganley, 1995). Perpetrators

use varying combinations of physical force and/or threats of harm and intimidating acts to instill fear in victims. At times they will use other kinds of manipulations through gifts, promises, and indulgences. Regardless of the tactic chosen, the perpetrators' intent is to get something from the victims, to establish domination over them, or to punish them. Perpetrators selectively choose tactics that work to control their victims. (Ganley, 1981; Serum, 1982; Pence & Paymar, 1993). See Appendix B for Power and Control Wheel.

II. CAUSES OF DOMESTIC VIOLENCE

A. Domestic Violence: Learned Behavior

Domestic violence is behavior learned through observation and reinforcement. Like other forms of aggression, domestic violence is not caused by genetics or illness. People are not born perpetrators and for the most part there is no disease or illness that turns a non-abusive person into an abuser. Domestic violence is a behavior acquired over time through multiple observations and interactions with individuals and institutions (Bandura, 1979; Dutton, D., 1988). The behaviors, as well as the perpetrator's internal "rules and regulations" about when, where, against whom, how, and by whom domestic violence is to be used, are learned. Domestic violence and the beliefs that support it are learned through direct observation (e.g., the male child witnessing the abuse of his mother by his father or from the proliferation of images of violence against women in the media). It is also learned through the reinforcement of the perpetrators' experiences (e.g., perpetrators receiving peer support or not being held responsible,

arrested, prosecuted, or sentenced appropriately for their violence).

Domestic violence is observed and reinforced not only in the family but also in society. It is overtly and covertly reinforced by society's major institutions: familial, social, legal, religious, educational, mental health, medical, entertainment, and the media (Bandura, 1977; Dutton, D. 1988; Ganley, 1989; Dobash & Dobash, 1979). These social institutions advocate the use of violence as legitimate means of controlling family members (e.g., religious beliefs/positions that state that a woman should submit to the will of her husband, laws that do not consider violence against intimates a crime, medical and mental health systems that blame victims for "provoking" the violence). These practices reinforce the use of violence to control intimates by failing to hold perpetrators responsible for their actions and by failing to protect victims. (See Jones (1994) for a more complete discussion of social supports for battering.)

Domestic violence is repeated because it works and thus the pattern of behavior is reinforced. The use of the abusive conduct allows the perpetrator to gain control of the victim through fear and violence. Gaining

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the victim's compliance, even temporarily, provides partial reinforcement for the perpetrator's use of abusive tactics. Often the battering behavior is also reinforced by the responses of peers, family authorities, and bystanders. More importantly, the perpetrator is able to reinforce his own abusive behavior. He is able to justify his actions to himself because of the socially sanctioned belief that men have the right to control women in relationships and have the right to use force to ensure that control.

B. Domestic Violence and Gender

Domestic violence is a gender-specific behavior which is socially and historically constructed. Men are socialized to take control and to use physical force when necessary to maintain dominance. While most victims of male violence are other men, the majority of victims of domestic violence are female, although female-to-male, male-to-male (gay), and female-to-female (lesbian) violence also occurs in intimate relationships. Male violence against women in intimate relationships is a social problem condoned and supported by the customs and traditions of a particular society. There is a great deal of discussion about whether gender is the sole factor determining the pattern of abusive control in intimate relationships or one of a cluster of significant variables (Miller, 1994; Renzetti, 1994). However, gender is clearly a salient issue when considering the following factors: the prevalence of male-to-female domestic violence, injuries to female victims, the use of physical force as part of a pattern of dominance, and specific responses of victims and perpetrators to domestic violence.

As previously noted, in the majority of reported domestic violence cases, the perpetrators are men and the victims are women (Douglas, 1991). In heterosexual relationships, some women sometimes use physical force, but their use of physical

force is not always at the same rate or severity as men's (Dobash & Dobash, 1979, 1992; Gelles, 1994). Studies indicate that while both men and women sometimes use similar physical behaviors, the physical effects of male violence are far more serious than female aggression as measured by the frequency and severity of injuries (Berk, Berk, Loseke, & Rauma, 1983). Furthermore, the impact of the physical aggression varies according to the gender of the victim — female victims of male intimate violence experience more negative consequences than male victims of female intimate violence (Vivian & Langhinrichsen-Rohling, 1994).

Furthermore, the purpose of women's use of physical force appears to be different than men's. In studies of heterosexual relationships, women use physical force against partners for self-defense, whereas men use force for power and control (Saunders, 1986; Hamberger & Potente, 1994; Jacobson, et al., 1994). In homicide studies, women are shown to be more likely than men to have committed homicide in self-defense. In contrast, male perpetrators of homicide are more likely to stalk victims, kill victims and/or other family members, and/or commit suicide than female perpetrators of homicide (Wilson & Daly, 1992). The research on battered women who kill also suggests that women's use of physical force is related to protecting themselves from the severe violence of male perpetrators (Gillespie, 1989). Browne (1987) found no distinguishing characteristics between battered women who kill and those who do not. The only differences found in comparing these two groups of battered women were found in their batterers (i.e., the men who were killed had been more violent against the victims as well as the children than those who were not killed).

Obviously, in same-sex domestic violence the gender pattern is different. However, the reality of same-sex domestic violence does not discount the gender issues of domestic violence. Male violence against women in heterosexual intimate relationships is a paradigm for intimate

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violence in gay and lesbian relationships: one partner is intimidating and controlling the other through the use of or threat of physical violence.

Even though the gender pattern is not the same for same-sex relationships as for heterosexual, there are gender issues related to how gay and lesbian victims and perpetrators relate to the abuse and to how others view same-sex domestic violence. For example, because of their gender socialization, gay victims may have difficulty identifying as victims because it is seen as "unmanly" (Letellier, 1994); the gay community may discount the violence because "that is the way men are" while the lesbian community may deny lesbian domestic violence because "women are not like that;" and the homophobic mainstream dismisses the domestic violence as just part of being gay or lesbian. While same-sex domestic violence is slowly receiving attention in the literature (e.g., Lobel, 1986; Renzetti, 1992; Letellier, 1994), there have been no studies comparing heterosexual, lesbian and gay domestic violence. Consequently, additional questions regarding gender and domestic violence still need to be answered.

C. Domestic Violence and Cultural Issues

Domestic violence occurs in all cultural/ethnic groups both outside and within the United States. Cross-cultural studies involving non-literate societies (Levinson, 1989; Campbell, J., 1993; Erchak & Rosenfeld, 1994) indicates that wife beating is more typical than husband beating in those societies and that the prevalence and severity of wife beating is influenced by a variety of social factors within a particular society (e.g., tolerance of violence, competitiveness between men and women, presence of support networks for women). While a review of that literature is beyond the scope of this chapter, it is referenced here as a reminder that domestic

violence is socially constructed and learned.

While researchers seek to understand the significance of cultural differences as related to domestic violence,³ it is helpful for the health care provider to focus on what is known. Domestic violence occurs in all cultural/ethnic groups and has serious physical and emotional consequences for victims, their children and their communities. The health impact of domestic violence to victims has been documented in various ethnic groups: Latino, African American, Asian, Native American, and Caucasian.

Cultural factors should not be used to dismiss the reality of domestic violence in a patient's life. Perpetrators and others will sometimes offer various cultural rationalizations for the conduct (e.g., "That's the way she knows I love her," "It's part of our culture," "It is their way of life") and there may be certain cultural specificity in the expression of those rationalizations (e.g., "_____ women are very violent, too"). This "cultural defense" for domestic violence has even been inappropriately offered in courts in attempts to explain away domestic violence homicides.

Culture sometimes shapes the specific tactic of control used by the perpetrator. Some perpetrators use cultural factors of the victims as a way to further the abusive control (e.g., immigrant status, language skills). Perpetrators may accuse victims of acting "uppity," "American," "white" or of being a "bitch" when they assert their human rights. These tactics of control are shaded with cultural issues to give the perpetrator dominance over the victim.

While culture does not alter the reality

³ There is conflicting data in the U.S. as to whether domestic violence is more prevalent within one ethnic group when compared with other ethnic groups (Straus & Gelles, 1990). When differences have been found, various explanations for those differences have been suggested. More research is needed to fully understand the connection (see Hawkins, 1986; Lockhart, 1987; Brice-Baker, 1994; Marsh, 1993; Plass, 1993; Torres, 1993).

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of the health consequences of domestic violence, cultural factors can influence identification, assessment, and intervention for the problem. The cultural identities of both the patient and the health care provider may affect the identification and assessment of domestic violence. A health care provider unfamiliar with a particular ethnic group may misinterpret a patient's actions as indicative of abuse (e.g., avoidance of eye contact) or as indicating that she is not a battered woman (e.g., a victim's rage and threats against her abuser). Victims from different cultural groups have different values and beliefs about interpersonal communication, the role of health care providers, the role of police, and the role of family members which shape how they reveal or don't reveal their experience of domestic violence.

Cultural issues should be considered in designing effective responses and interventions for both the victims (Torres, 1993; Campbell, D., 1993; Ho, 1990; Hamptom, 1987; Jang, 1991; Plass, 1993) and the perpetrators (Williams, 1994). Just as health facilities have worked to offer all health care services in ways that are accessible to diverse populations with a variety of languages and ethnicities, responses to patients experiencing domestic violence must also be culturally appropriate.

D. Domestic Violence vs. Illness-based Violence

While domestic violence is learned, there is other violence that results from illness. A small percentage of violence against adult intimates is illness-based but is misidentified as domestic violence. This violence is caused by organic or psychotic impairments and is not part of a learned pattern of coercive control of an intimate partner. Individuals with diseases such as Alzheimer's disease, Huntington's Chorea, or psychosis may strike out at an intimate partner. Sometimes that violence gets identified as domestic violence.

An assessment will distinguish illness-based violence from learning-based violence. With illness-based violence, there is usually no selection of a particular victim (whoever is present when the short circuit occurs will get attacked: health care provider, family member, friend, stranger, etc.). However, with learning-based violence, the perpetrator directs his abusive conduct toward a particular person or persons. In addition, with illness-based violence there is usually a constellation of other clear symptoms of a disease process. For example, with an organic brain disease, there are changes in speech, gait, or physical coordination. With an illness such as psychosis there are multiple symptoms of the psychotic process (e.g., "He attacked her because she is a CIA agent sent by the Pope to spy on him using the TV monitor"). Poor recall of the event alone is not an indicator of illness-based violence (see Section III. B. 2. of this chapter on perpetrator minimization and denial). With illness-based violence the acts are strongly associated with the progression of a disease (e.g., the patient showed no prior acts of violence or abuse in the 20-year marriage until other symptoms of the organic process had appeared).

There has been no systematic research to determine the percentage of cases identified by police or courts as domestic violence that are attributable to illness. In a clinical sample of those individuals identified by community police and courts and referred to a medical center as domestic violence perpetrators, less than 5% were violent as a result of an organic process (Ganley, 1995). More research is needed on this issue.

Illness-based violence can be most effectively managed by appropriate medical or mental health interventions and case management (e.g., instituting day treatment programs, appropriate medications, respite care, institutionalization when necessary). While attention must be given to the safety of the victims in such cases, it is more appropriately dealt with by those knowledgeable about the particular illness. While the victim may benefit from

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emergency shelter services and safety planning, the perpetrator of illness-based violence would not benefit from specialized domestic violence interventions.

E. Domestic Violence Is Not Caused by Alcohol or Other Drugs

Many people use or abuse drugs without ever battering their partners. Alcohol and other drugs such as marijuana, depressants, anti-depressants, or anti-anxiety drugs do not cause individuals to become violent. Although alcohol and drugs may be used as the excuse for the battering, research indicates that the complex pattern of coercive behaviors which comprise domestic violence is not caused by consuming particular chemicals (Critchlow, 1986; Taylor & Leonard, 1983; Pihl & Smith, 1988, Gondolf & Foster, 1991).

Some people who consume alcohol or drugs are violent with or without the chemical in their bodies. An addict's violence may be part of a lifestyle where everything, including family life, is orchestrated around the acquisition and consumption of the drug. Other addicts are so focused on their addiction that they withdraw from relationships and do not engage in any controlling behavior directed at family members.

On the other hand, there is conflicting evidence whether certain drugs (e.g., steroids, PCP, speed, cocaine or cocaine's derivative, "crack") chemically react within the brain to cause violent behavior or whether they induce paranoia or psychosis, which is then sometimes accompanied by violent behaviors. Further research is needed to explore the cause-and-effect relationship between those particular drugs and violence.

While research studies cited above have found high correlations between aggression and the consumption of various substances, there is no data clearly proving a cause-

and-effect relationship. There are a wide variety of explanations for these high correlations. Some say that alcohol and drugs provide a disinhibiting effect which gives the individual permission to do things that they otherwise would not do. Others point to the increased irritability or hostility which some individuals experience when using drugs and which may lead to violence. Others state that the high correlations merely result from the overlap of two widespread social problems: domestic violence and substance abuse.

Clinical experience cautions against viewing domestic violence as being caused by alcoholism, drug addiction or substance abuse. Such a view can misdirect interventions solely to the chemical use rather than to the domestic violence. For those who are addicted to alcohol and other drugs, stopping domestic violence behavior is difficult without also stopping the addictions. However, it is not sufficient to treat the chemically addicted perpetrator of domestic violence solely for either addiction or domestic violence. Interventions for both require one of the following: (a) concurrent interventions for domestic violence and substance dependence/abuse, (b) inpatient substance abuse treatment with a mandatory follow-up program for domestic violence, or (c) an involuntary substance abuse commitment (which is done in some, but not all, states) with rehabilitation directed at both the addiction and the domestic violence.

The presence of alcohol or drugs is highly relevant to the assessment of lethality. The use of, or addiction to, substances may increase the potential lethality of domestic violence and must be carefully considered when addressing the safety of the victim, the children, and the community (Browne, 1987).

F. Domestic Violence Is Not Caused by Anger

The role of anger in domestic violence

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is complex and cannot be simplistically reduced to one of cause-and-effect. Some battering episodes occur when the perpetrator is not angry or emotionally charged, and others occur when the perpetrator is emotionally charged or angry. Some abusive conduct is carried out calmly to gain the victim's compliance. Some displays of anger or rage by the perpetrator are merely tactics used to intimidate the victim, and can be quickly altered when the abuser thinks it is necessary (e.g., upon arrival of police).

Current research indicates that there is a wide variety of arousal or anger patterns among identified perpetrators as well as among those who are identified as not abusive (Gottman et al., 1995; Jacobsen et al., 1994). These studies suggest that there may be different types of batterers. Abusers in one cluster actually reduced their heart rates during observed marital conflicts, suggesting a calm preparation for fighting rather than an out-of-control or angry response. Such research challenges the notion that domestic violence is merely an anger problem and raises questions about the efficacy of anger-management programs for batterers.

Remembering that domestic violence is a pattern of behaviors rather than isolated, individual events helps to explain the number of abusive episodes that occur when the perpetrator is not angry. Even when experiencing anger, the perpetrator still chooses to respond to that anger by acting abusively. Ultimately, the individual is responsible for how he expresses anger or any other emotion.

G. Domestic Violence Is Not Caused by Stress

Life is filled with many different sources of stress (e.g., stress from the job, stress from not having a job, relationship conflicts, losses, illness, discrimination, or poverty). People respond to stress in a wide variety of ways (e.g., problem solving,

substance abuse, eating, laughing, withdrawal, and violence) (Bandura, 1973). People choose ways to reduce stress according to what they have learned about strategies that have worked for them in the past.

It is important to hold individuals responsible for the choices they make regarding how they reduce stress, especially when those choices involve violence or other illegal behaviors. A robbery or a mugging by a stranger is not excused simply because the perpetrator claims he is stressed. Similarly, the perpetrator of domestic violence cannot be excused simply because he is stressed. Moreover, as already noted, many episodes of domestic violence occur when the perpetrator is not emotionally charged or stressed. Since domestic violence is a variety of tactics repeated over time for the purpose of controlling the victim, specific stresses are less meaningful in explaining a longitudinal pattern of abusive control (Pence & Paymar, 1993).

H. Domestic Violence Is Not Caused by the Victim's Behavior or by the Relationship

People can be in conflicted relationships and experience negative feelings about the behavior of their partner without choosing to respond with violence. Focusing on the relationship or the victim's behavior as an explanation for domestic violence removes the perpetrator's responsibility for the violence and coercion and supports the perpetrators' minimization, denial, blaming, and rationalization for the violent behavior. Blaming the victim for making the perpetrator angry, or blaming the violence on problems in the relationship (e.g., poor communication) provides the perpetrator with excuses and justifications for the conduct. This reinforces the perpetrator's use of abuse to control family members and thus contributes to the

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escalation of the pattern of domestic violence.

Many batterers bring this pattern of control into their adult relationships and repeat it in all their adult intimate relationships, regardless of significant differences in the personalities or conduct of their intimate partners or in the characteristics of those particular relationships. These variables in partners and relationships supports the position that while domestic violence takes place within a relationship, it is not caused by the relationship. Research indicates that there are no personality profiles for battered women (Hotaling & Sugarman, 1986). Battered women are no different from non-battered women in terms of psychological characteristics. Once again, this challenges the myth that there is something about the woman that causes the perpetrator's violence. Furthermore, a study by Jacobson et al. (1994) indicates that no victim behavior could alter the perpetrator's behavior. This also suggests that the victim's behavior

is not the determining factor in whether or not the perpetrator is abusive.

Domestic violence in adolescent relationships further challenges the notion that the abuse is the result of the victim's behavior. Often times the adolescent abuser only superficially knows his victim, having dated her only a few days or weeks before beginning the abuse. Such an abuser is often acting out an image of how to conduct an intimate relationship based on the recommendations of his peers, music videos, models set by family members, etc. The adolescent's abusive conduct is influenced more by that image or script than by the victim's behavior.

Both adult and adolescent batterers bring into their intimate relationships certain expectations of who is to be in charge and what mechanisms are acceptable for enforcing that dominance. Those attitudes and beliefs, rather than the victim's behavior, determine whether or not they are violent.

III. DOMESTIC VIOLENCE: THE VICTIM, THE PERPETRATOR, THE CHILDREN AND THE COMMUNITY

A. The Victim

Victims of domestic violence have multiple health problems as a result of the abusiveness of their partners. They seek medical care for injuries resulting from the perpetrators' acts (e.g., burns, broken bones, internal injuries, vaginal injuries, miscarriages, head injuries, damage to eyes or ears, dental injuries, knife or gunshot wounds, cuts, back injuries) and with illnesses aggravated by the stress of living with their partner's abusiveness (e.g., asthma, lupus, MS, depression, anxiety, insomnia, eating disorders).

Victims may also be patients in the

health care system for issues seemingly unrelated to their victimization, and their treatment for their medical conditions may be compromised by the continuing abuse (e.g., an insulin-dependent patient whose perpetrator controls her by withholding her medications or by refusing to allow her to keep her medical appointments). This victimization by intimate partners puts patients at future risk for medical and psychological sequelae to abuse.

If the domestic violence is not identified and addressed, there are both long and short-term consequences for the victims. Unidentified victims may receive inappropriate treatments for their presenting injury

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or illness (e.g., over-medications, treatment protocols they are unable to carry out due to the control of the abusers) and/or they may be denied the opportunity to get the information and support they need to protect themselves from future injuries, illnesses or death.

Failure to identify victims of abuse also creates consequences for the health care system. The health care practitioner misses the opportunity for early identification, intervention and ultimate prevention. Initial injuries and illnesses are followed by repeated injuries and illnesses due to the violence. Victims seeking assistance return to the health care system for multiple visits, consuming scarce resources. For some victims the only professional with whom they have contact is the health care provider and they will return again and again in hopes that their suffering will be alleviated.

1. VICTIMS OF DOMESTIC VIOLENCE CAN BE FOUND IN ALL AGE, RACIAL, SOCIOECONOMIC, EDUCATIONAL, OCCUPATIONAL, RELIGIOUS, SEXUAL ORIENTATION AND PERSONALITY GROUPS

Victims of domestic violence are a very heterogeneous population whose primary commonality is that they are being abused by someone with whom they are, or have been, intimate. They do not fit into any specific age group, racial group, personality profile, socioeconomic, educational, occupational, religious or sexual orientation.

Too often, victimization is seen as a problem for one group but not for another. For example, teen victims of domestic violence are often ignored. While there is a great deal of public discussion about the need for appropriate sex education to help teens protect themselves from unwanted disease or pregnancy, there is little awareness of the need for teen education about domestic violence. With further documen-

tation of dating violence (Levy, 1991), there is a call for more attention to this issue by those professionals in contact with adolescents who are just beginning to have intimate relationships. They need assistance in specific ways to avoid violence in their dating relationships. Victims of partner abuse may be 12, 25, 43, 78, 98 or any age in between. All age groups have the potential to be victimized by perpetrators of domestic violence.

Sometimes ignoring the issue takes the form of stereotypes that communicate that wife beating is just a way of life or "culturally acceptable" in "that" group. As noted previously, there is little comprehensive research on the prevalence and "acceptability" of domestic violence in specific groups (e.g., certain cultural groups, gays, lesbians). What research has been done raises as many questions as it answers. What is known is that domestic violence is a problem in all racial, ethnic, sexual orientation, ability, economic class, educational, and occupational groups.

Furthermore, there is no evidence that battered women fit a particular personality profile. Early studies of battered women attempted to focus on characteristics of the victim that would provide a causative explanation for the violence (Snell, Rosenwald, & Robey, 1964). Later studies indicate that no causative link has been found between the characteristics of battered women and their victimization (Hotaling & Sugarman, 1986). Consequently, as with victims of other trauma (e.g., car accidents, floods, muggings), there is no particular personality profile for the person who is battered. Being a victim of domestic violence is due to behaviors of the perpetrator, rather than the personal characteristics of the victim.

2. VICTIMS MAY OR MAY NOT HAVE BEEN ABUSED AS CHILDREN, OR IN PREVIOUS RELATIONSHIPS

Just as some have looked to the person-

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ality or demographic characteristics of the victim to explain her victimization, others have suggested that most domestic violence victims have a history of childhood abuse and/or previous violent relationships, and that this contributes to the current victimization. Yet there is no evidence that previous victimization, either as adults or as children, results in women seeking out or causing their current victimization (Dutton, M.A., 1992). Some victims of domestic violence have been victimized in the past and some have not. While it may be helpful to understand an individual victim's history and her coping strategies in dealing with past and current abuse, the practitioner should exercise caution and avoid making victim blaming interpretations of such history.

3. SOME VICTIMS BECOME VERY ISOLATED AS A RESULT OF THE PERPETRATORS' CONTROL OVER THEIR ACTIVITIES AND CONTACTS WITH FRIENDS AND FAMILY MEMBERS

Some of a victim's behaviors in a health care setting can be understood in light of the control the perpetrator has managed to enforce through her isolation (e.g., her reluctance to commit to a particular treatment protocol that requires multiple appointments, her lack of confidence in her own abilities, or her fear of further harm).

Without outside contact and information, it becomes more difficult for the victim to avoid the psychological control and threats of the perpetrator. Some victims come to believe their abuser when they say the victims would not survive alone if they left, while others resist such distortions.

Even when the victim maintains contact with friends or extended family, those relationships are often mediated through the control of the perpetrator. Consequently, victims do not experience needed support and advocacy. The victim's experience with others is repeatedly

processed through the comments and interpretations of the abuser. Some perpetrators interrogate victims about every detail of their interactions with others and describe to the victims the nature of those relationships. The victims' positive feedback or support from their other relationships is undermined by the perpetrators' intrusions into those relationships. The more successful perpetrators are in isolating the victims, the more they control what the victims believe (Graham & Rawlings, 1991).

4. WHY SOME VICTIMS STAY/WHEN THEY LEAVE

One of the most commonly asked questions about domestic violence is, "Why do victims stay in violent relationships?" The reality is that many victims leave. But to understand this process of leaving, one must once again consider what domestic violence is, what the perpetrator is doing, and what the victim's options are in her community.

The primary reason given by victims of domestic violence for staying or returning to the perpetrator (or for not following other health care provider recommendations) is fear of violence and the lack of real options for safety with their children. This fear of the violence is realistic. Research on battered women shows that the lethality of the perpetrator's violence often increases when the perpetrator believes that the victim has left or is about to leave the relationship (Campbell, J., 1992, Wilson & Daly, 1993). The literature suggests several indicators for homicide against the victim: the perpetrators' obsession with the victim, a pattern of escalating physical violence, increased risk-taking by the batterer, threats to kill the victim and self, substance abuse, and a gun in the household (Campbell, J., 1992; Saunders, 1994; Hart & Gondolf, 1984; Kellerman, et al., 1993).

Some perpetrators repeatedly threaten or attempt to kill or seriously injure their victims, children or others when the victims attempt to leave relationships. The victim

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may have previously attempted to leave only to have been tracked down by the perpetrator, seriously injured and brought back. Perpetrators do not just let victims leave relationships. They will use violence and all other tactics of control to maintain the relationship. It is a myth that victims stay with perpetrators because they like to be abused. Even in cases where the victim was abused as a child, the victim does not seek out violence and does not want to be battered. Staying in or returning to the relationship may simply be safer than leaving.

The reasons for staying in a violent relationship are multiple and vary for each victim. They include:

- a. Fear of the perpetrator's violence;
- b. Immobilization by psychological and physical trauma;
- c. Connection to the perpetrator through his access to the children;
- d. Illness (e.g., HIV, MS) and dependence on the perpetrator for health care;
- e. Belief in cultural/family/religious values that encourage the maintenance of the family unit at all costs;
- f. Continual hope and belief in the perpetrator's promises to change and to stop being violent;
- g. Belief that the perpetrator cannot survive (e.g., due to illness with AIDS) or will engage in self-destructive behavior if the victim leaves;
- h. Insufficient funding and resources nationwide that result in a lack of shelters and victim advocacy programs to provide transitional support;
- i. Lack of real alternatives for employment and financial assistance, especially for victims with children;
- j. Lack of affordable legal assistance

necessary to obtain a divorce, custody order, restraining order, or protection order;

- k. Lack of affordable housing that would provide safety for the victim and children;
- l. Being told by others that the abuse is happening because the victim is gay, lesbian, or bisexual and that the abuse would stop if they would "change;" and
- m. Being told by the perpetrator, counselors, the courts, police, ministers, family members, or friends that the violence is the victim's fault, and that the victim could stop the abuse simply by complying with the perpetrator's demands. In these cases, the victims learn that the systems with the power to intervene will not believe them or act to protect them. Thus, the victims are forced to comply with the perpetrators in hopes of stopping the abuse.

5. VICTIM SURVIVAL STRATEGIES

Victims of domestic violence use many strategies to survive that become inappropriately labeled as "crazy," codependent, or inappropriate behavior on the part of the victim (e.g., being too fearful to ask partner to use safe sex precautions, being afraid to use legal remedies or seek battered women's advocacy services, or wanting to return to the perpetrator in spite of severe violence). These victim responses may in fact be normal reactions or strategic decisions for coping with very frightening and dangerous situations (Dutton, M.A., 1992).

When the victim discovers that a system with the power to intervene will not act to safeguard and support her, she may conclude that reconciliation is the safer course. The victim can rarely stop the perpetrator's abuse. All that she can do is to keep herself and her children as safe as possible, and even this requires the support of someone else. Some victims will begin to

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terminate the relationship by seeking assistance from the court system or social service agencies, only to see that those systems are not effective in stopping the violence. For example, a protective order may not deter a perpetrator in communities where the police refuse to enforce the order. Where outside protection fails, the victim is forced to rely on strategies that have worked in the past.

Victims use many different strategies to cope with and resist the abuse. Such strategies include agreeing with the perpetrator's denial and minimization of the violence in public, accepting the perpetrator's promises that it will never happen again, saying that she "still loves him," being unwilling to leave the perpetrator or terminate the relationship, and doing what he asks. These strategies may appear to be the result of passiveness or submission on the part of the victim, when in reality she has learned that these are sometimes successful approaches for temporarily avoiding or stopping the violence. Many victims who appear reluctant to carry out actions that the health care provider believes would protect them and their children from further violence actually have the same goal as the health care provider: namely, an end to the violence. They simply have different strategies.

Some victims have told other health care providers about the abuse, even if they did not use the terms "abuse" or "domestic violence." In the past their descriptions of the abuse may have been ignored, not believed, or met with inappropriate responses. It can be very humiliating to the victim to talk about these issues with someone who is not sensitive. Because of prior attempts to seek assistance from the health care system or other social service agencies, the victim may now be reluctant to assume that her safety and confidentiality will be respected by the current health care provider. In such cases, unless the health care provider initiates the topic, the victim may not even raise the issue with the health care provider. Other victims will readily name the abuse, but minimize it as a way to cope with what is happening until they can determine whether there really are the

community supports they need for protection. In such cases, victims sometimes re-engage in the prior survival strategies of complying with the perpetrators while they assess the community.

Successful interventions must be based on an understanding of the victim's behavior as normal responses to violence perpetrated by an intimate. Rather than viewing the victim's behaviors as masochistic, passive, crazy, or inappropriate, they should be viewed as survival strategies which contribute to the victim's safety and the safety of her children.

B. The Perpetrators

Perpetrators come into the health care system both for problems related to their abusive behaviors and for those that are not. They are patients in emergency departments, primary care practices, or specialty clinics. They may be inpatients or outpatients. There are few published studies of prevalence for domestic violence perpetrators in the various clinics serving men (except Gondolf & Foster, 1991). However, certain medical centers (e.g., Veterans Administration Medical Centers, military medical facilities, some HMO's) with on-site perpetrator intervention programs do report receiving referrals of abusers from medical personnel who see these patients in a wide variety of medical clinics.

Perpetrators sometimes seek health care assistance for physical injuries they caused to themselves in the process of striking their partners or when terrorizing them with attacks against property (e.g., broken hands, feet, limbs, back injuries, head injuries, internal injuries, muscle strains, burns, cuts). Sometimes they are seeking medical attention for illnesses aggravated by their abusive behavior (e.g., diabetes, asthma, high blood pressure, heart problems, depression). Sometimes they have injuries from suicide attempts made to coerce their partners to remain in the relationship. One abuser shattered the

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bone of his lower leg when the sledgehammer he was using to destroy his partner's apartment kicked back.) Another terrorized his partner by telephoning her and threatening for 30 minutes to kill himself with dynamite. As she listened helplessly, he blew off one of his arms. Both men were identified as domestic-violence perpetrators by medical personnel during treatment for their physical injuries and were referred to domestic violence intervention programs.

Sometimes perpetrators are seeking medical care for injuries caused by the victims' desperate attempts to protect themselves or their children or by victims who strike back after years of abuse (e.g., injuries from objects being thrown, burns, knife or gunshot wounds). Sometimes the batterers are in the system for problems totally unrelated to their abusive behavior (e.g., bone marrow transplant, spinal cord injury, post traumatic stress disorder, schizophrenia, gall bladder surgery).

There is no simple, predictive profile that can be used to determine whether or not someone is a perpetrator of domestic violence. However, there are some common characteristics of abusers that are helpful to keep in mind when interacting either with a victim or with a perpetrator.

1. PERPETRATORS OF DOMESTIC VIOLENCE CAN BE FOUND IN ALL AGE, RACIAL, SOCIOECONOMIC, EDUCATIONAL, SEXUAL ORIENTATION, OCCUPATIONAL, AND RELIGIOUS GROUPS

Perpetrators are a very heterogeneous population whose primary commonality is their use of violence. They may be young, old, or in-between. They may be artists, athletes, teachers, health care providers, professionals, working class, unemployed, middle class, rich, or poor. They may be Protestant, Catholic, Muslim, Jewish, Buddhist, agnostic, or atheist.

Perpetrators do not fit into any specific personality or diagnostic category. While there is a great deal of discussion in the literature about the psychological profile of batterers, especially as it relates to predicting outcome in their rehabilitation (Saunders, 1993), it is premature to offer personality profile(s) for abusers. There appear to be clusters of personality characteristics for different abusers (Tolman & Bennett, 1990; Hamberger & Hastings, 1990; Saunders, 1992), just as there are clusters of personality characteristics for non-abusers. The literature suggests that there are different types of batterers who use different controlling tactics to different degrees (Gondolf, 1988; Issac, Cockran, Brown & Adams, 1994). Part of this variance may be explained by different types of batterers or by the fact that those studied are at different stages in their own histories as batterers.

The diversity of perpetrators is limited only by the diversity represented in a community. Sometimes a health care provider or community agency will deal with one group more than another (e.g., a particular socioeconomic class, ethnic group, or age group). This may lead to some inaccurate generalizations about perpetrators (or victims) as providers start to think of abusers solely in terms of the cases they see. In order not to make errors in identification of domestic violence, the health care provider should remain open to the possibility of domestic violence being an issue for diverse individuals. Clinical experience is a reminder that perpetrators come in many forms and ultimately can only be identified by knowing how they relate to their intimate partners.

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2. DOMESTIC VIOLENCE PERPETRATORS AVOID TAKING RESPONSIBILITY FOR THEIR CONDUCT BY MINIMIZING, DENYING, LYING ABOUT OR JUSTIFYING THEIR ABUSIVE TACTICS

Perpetrators minimize their abusive conduct and its impact on the victim and others by making the abuse appear less frequent and less severe than it really is (e.g., "I only hit once," "I just pushed her to the floor," "The children never saw the abuse," "She bruises easily," "I'm not one of those wife-beaters. I have never punched her"). In talking with others about the problem, perpetrators will sometimes use euphemisms for their violence, such as "We're not getting along so well" or "We had a little fight last night," when referring to incidents in which the victim required major medical attention for serious injuries.

Sometimes perpetrators acknowledge what they do, but justify it by externalizing responsibility for their behavior to others or to factors supposedly outside their control. The health care provider will hear many different ways abusers justify or blame others for their abusiveness. Perpetrators primarily blame the victims for the violence: "She wouldn't listen to me," "She's an alcoholic," "She's crazy," "I can't handle her," "My lover is the abuser," "This pregnancy has made her wild," "She's suffering from post-partum depression," "She's clumsy," or "She's running around on me." They also blame other factors: "I have PTSD (post-traumatic stress disorder)/hypoglycemia/ attention-deficit disorder/mood swings," "I was drinking," "The kids are just too much," or "The EMT got his facts wrong. I didn't do nothing that you wouldn't do." Sometimes they do not lie about their behavior because they believe they have the right to do what they do. When blaming, perpetrators fail to mention their violent behaviors and avoid taking responsibility for them.

Sometimes perpetrators lie about their abuse to avoid the external consequences of their behavior and to maintain control over their partner. They will lie to the victim, family, friends, police, judges, health care providers, and anyone else who has contact with them. They lie because they do not want to deal with possible consequences (e.g., arrests, prosecution, jail, loss of visitation, etc.).

Sometimes perpetrators use denial and minimization not only to avoid the external consequences but also to protect themselves from the personal discomfort of recognizing that they are abusing someone they love. This denial is a means of deceiving themselves. Just as there are alcoholics who are in denial about their drinking, there are perpetrators in denial about their battering. There are some perpetrators who are conflicted about what they are doing and they distort it through minimization, denial, or rationalization to make it more acceptable to themselves.

Regardless of why a perpetrator is distorting the truth, this distortion can be misleading to both victims and to health care providers and can present barriers to identifying domestic violence. Health care providers should be aware of perpetrators' tendency to lie, deny, or minimize the violence and avoid colluding with abusers.

3. DOMESTIC VIOLENCE PERPETRATORS CONTROL THE VICTIM THROUGH THE HEALTH CARE SYSTEM

Perpetrators use multiple tactics of control against the victim. Sometimes they enlist others in that control either through disinformation or intimidation. The tactics of control may be used to coerce the victim to stop talking about the abuse with the health care worker, to reunite with the perpetrator, to drop her objections to joint custody, etc. The following are examples of controlling behaviors that the health care practitioner may witness or hear about.

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- Physical assaults or threats of violence against the victim, children, or sometimes the health care provider; threats of suicide; threats to take the children or harassment;
 - Stalking the victim to and from health care appointments;
 - Accompanying the victim to all appointments; sending the victim "looks" during appointments; refusing to let the victim be interviewed or examined alone;
 - Bringing family or friends to the medical facility to intimidate or cajole the victim or the health care provider;
 - Blaming the victim through long speeches about all the victim's behaviors that supposedly "provoke" the abuse;
 - Crying and other displays of emotion or statements of profound devotion or remorse to the victim, alternated with threats or other psychological abuse;
 - Canceling the victim's appointments with the health care provider; sabotaging her efforts to attend appointments by not providing child care, transportation, etc.;
 - "Physician-hopping" or "therapist-hopping;"
 - Denying the victim access to the perpetrator's medical records that may support her issues or attempting to control or gain access to her medical records;
 - Withholding medication; under- or over-medicating the victim;
 - Using the legal system against the victim by requesting mutual orders of protection, making false charges of harassment/abuse against the victim, filing multiple divorce proceedings;
 - Continually testing the limits of visitation/support agreements by arriving late or not showing at appointed times or arriving drunk;
 - Threatening and/or implementing custody fights; and
 - Using any evidence of damage resulting from the abuse as evidence that the victim is an unfit parent (victim's counseling records, victim's treatment for depression or other medical conditions, etc.).
- Sometimes in his attempts to control the victim, a perpetrator will attempt to control the health care provider with the same tactics of power and control used against the victim.
- Portraying self as the good patient who constantly praises the health care provider;
 - Intimidating the health care provider with a variety of threats or acts;
 - Harassment of health care provider by repeated phone calls, civil suits or threats of legal action, or false reports to superiors concerning supposed breaches of confidentiality, inappropriate treatment, or rude behavior;
 - Splitting health care teams by creating divisiveness among professionals (e.g., "The doc is one of those women's libbers," "The nurse doesn't like me," "He takes my wife's side").

4. DOMESTIC VIOLENCE PERPETRATORS MAY HAVE GOOD QUALITIES IN SPITE OF THEIR ABUSIVENESS

Some domestic violence perpetrators may be good providers, hard workers, good conversationalists, witty, charming, attrac-

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tive, and intelligent, yet they still batter their victims. Sometimes health care providers as well as victims are misled by these positive qualities and assume that the violence did not really happen or is an aberration of the perpetrator's real personality since only individuals who are "monsters" could commit such acts. They may believe that the violence can be ignored because such a "good" person will most certainly stop the abuse. The reality is that even seemingly normal and nice people may batter and may be very dangerous. Battering stops only when perpetrators are held responsible for both their abuse and for making the changes necessary to stop the violence.

C. The Children

Children, like the victim, appear in the health care system with a variety of physical injuries, illnesses or medical conditions directly related to the perpetrator's abuse and with other health issues. Understanding the domestic violence etiology of those conditions is important both in treating the current conditions and in preventing future problems. Even if the child's problem is not related to the domestic violence, treatment for any condition can be compromised by the abusive, controlling behavior of the batterer.

1. PERPETRATORS TRAUMATIZE CHILDREN IN THE PROCESS OF BATTERING THEIR ADULT PARTNERS

Perpetrators of domestic violence traumatize and terrorize children in four ways:

- a. By intentionally injuring the children as a way of threatening and controlling the victim (e.g., a child is used as a physical weapon against the victim by being thrown at the victim or a child is physically or sexually abused as a way to coerce the victim to do certain things);
- b. By unintentionally injuring the children during the attack on the abused parent when the child gets caught in the fight or attempts to intervene (e.g., an infant is injured when the mother is pushed against the wall while holding the child; a small child is kicked when trying to stop the perpetrator's attack against the victim);
- c. By creating an environment where children witness the abuse or its effects. Research reveals that children who witness domestic violence are affected in the same way as children who are physically and sexually abused (Goodman & Rosenberg, 1987). In spite of what perpetrators may say, children have often either directly witnessed the physical and psychological assaults or have indirectly witnessed it by overhearing the episodes or by seeing the aftermath of the injuries and property damage; and
- d. By using the children to coercively control the abused partner while the victim is living with the perpetrator and when the partners are separated. The intent is to continue the abuse of the adult victim, sometimes with little regard for the damage this controlling behavior has on the children (Walker & Edwall, 1987).

Examples of the perpetrator's behavior that traumatizes and terrorizes children include but are not limited to:

- Asserting that the children's "bad" behavior is the reason for the assault on the victim;
- Isolating the children along with the abused parent (e.g., not allowing the children to enter peer activities or friendships);
- Engaging the children in the abuse of the other parent (e.g., making the child participate in the physical or emotional assaults against the adult);

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- Forcing the children to watch the violence against the abused parent;
- Threatening violence against the children, pets, or other loved objects. Attacks against pets or loved objects are particularly traumatic for young children who often do not make a distinction between themselves and the pet or object. Consequently, the perpetrator's attack against the pet is experienced by the children as an attack against them;
- Interrogating the children about the abused parent's activities;
- Forcing the abused parent to always be accompanied by the children;
- Taking the children away after each violent episode to ensure that the adult victim will not flee the perpetrator;
- Holding children hostage or abducting the children in efforts to punish the victim or to gain the victim's compliance;
- Using lengthy custody battles as a way to continue abusing the other parent;
- Engaging in long tirades aimed at the children about the abused parent's behaviors that caused the separation; and
- Demanding unlimited visitation or access by telephone (e.g., insisting that adolescent siblings stay alternate nights with the perpetrator after the separation, ignoring their need for time with each other or with their friends)

2. CONSEQUENCES OF DOMESTIC VIOLENCE ON CHILDREN

Children living with domestic violence in the home are often the forgotten victims. Current research indicates that domestic

violence affects children in a variety of ways, and that the effects are both short- and long-term (Jaffe, Wolfe & Wilson, 1990; Peled, Jaffe & Edleson, 1994; Schecter & Edleson, 1994). Children may be physically, emotionally, and cognitively damaged as a result of domestic violence. The nature and extent of the damage caused by the perpetrator's violence will vary depending primarily on three factors:

- a. The type and history of abusive control used by the perpetrator;
- b. The age, gender, and developmental stage of the child;
- c. Situational factors, such as other social supports.

Consequences of the perpetrator's abuse vary according to the age and developmental stage of the child (Jaffe, et al., 1990). During infancy, the crucial developmental task for the very young child is the development of emotional attachments to others. Being able to make attachments to others provides a foundation for healthy development. Domestic violence not only interrupts the infant's attachment to the perpetrator but can also interrupt the child's attachment to the victim. The perpetrator may directly interfere with the victim's care of the young child. The perpetrator's violence may not permit bonding between either parent and the child. This results in difficulty for the child in forming future relationships and blocks the development of other age appropriate skills and abilities.

The primary tasks of children between ages five and ten are role development and cognitive development. The perpetrator's violence and pattern of control can impede or derail both of these tasks. For example, a child may have difficulty learning basic concepts in school because of his or her anxieties about what is happening at home.

The central developmental task of teenagers is becoming autonomous. This occurs as teens separate from relationships with parents and establish peer relation-

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ships. Often what is learned in family relationships is duplicated in peer relationships. Consequently, for teens living in violent homes there is no positive model for learning the skills necessary for establishing mutuality in healthy adult relationships (e.g., listening, support, non-violent problem-solving, compromise). The teenager will sometimes side with the abusive parent, viewing that parent as the one who is most powerful.

Like the adult victims, children experience a great deal of fear and have multiple ways of expressing that fear. The negative effects of the perpetrator's abuse in interrupting childhood development can be seen in cognitive, psychological, and physical symptoms (Jaffe, et al., 1990) such as:

- a. eating, sleeping disorders;
- b. mood related disorders such as depression and emotional neediness;
- c. overcompliance, clinginess, withdrawal;
- d. aggressive acting out/destructive rages;
- e. detachment, avoidance, a fantasy family life;
- f. somatic complaints;
- g. finger biting, restlessness, shaking, stuttering;
- h. school problems; and
- i. suicidal ideation.

The child's experience of domestic violence also results in changes in perceptions and problem solving skills. Young children often incorrectly see themselves as the cause of the perpetrator's violence against the intimate partner. Children will

use either passive behaviors (e.g., withdrawal, compliance) or aggressive behaviors (e.g., verbal and/or physical striking out) rather than assertive problem solving skills to cope with the problem.

3. CHILDREN, PARENTING, AND DOMESTIC VIOLENCE

In the face of overwhelming odds, battered women do many things to protect their children from perpetrators: intervening in the perpetrator's violence directed at the children, sending the children to others when they are in danger, teaching the children safety plans, reminding the children that they are not responsible for domestic violence, and being very loving and engaged with the children. Sometimes the victim cannot effectively protect the children from the perpetrator's violence because the victim is relatively powerless to protect herself from the perpetrator.

One of the goals of intervention for victims with children is for victims to get the support and advocacy necessary to effectively protect their children. The most effective way to protect the children is to protect and support the non-abusing parent. Removing the child from the care of a loving battered woman is not the answer. Nor is putting the child into a treatment program without also ensuring that he/she has a safe home. Holding the perpetrator, not the victim, responsible for the abuse is critical in protecting both the victim and the child.

Many children are not harmed irreparably by experiencing domestic violence in their families. A caring, supportive network can lessen the negative effects to children, helping them rebuild their sense of self as caring, competent beings. Once they are safe, they can return to normal developmental tasks.

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D. THE COMMUNITY

Domestic violence ripples out into the community when the perpetrator's violence results in the death or injury of those attempting to assist the victim or innocent bystanders. Such tragic consequences of domestic violence in the community can be seen on a daily basis in newspapers across the country as they recount the latest homicide of an ex-spouse, current partner, children, innocent bystanders, or those who attempt to intervene in the violence. Although rarely identified by the media as "domestic violence" homicides, these fatalities almost always involve a history of abusive and controlling behavior by the perpetrator against the adult intimate.

- In California, a domestic violence perpetrator kills the victim, his daughters, several of the victim's co-workers, and a police officer.
- In New York, the boyfriend of an employee burns down a nightclub,

resulting in numerous deaths of patrons inside.

- In Colorado, a lawyer is shot in court by a domestic violence defendant.
- In Washington, six residents of an apartment building die in a fire set by a perpetrator attempting to kill his ex-wife.
- In Washington, a battered woman, her unborn child, and two women friends are shot and killed in Superior Court by the husband before closing arguments in an annulment hearing.

There are also many financial costs of domestic violence that the community must bear in terms of medical care, absenteeism, and the response of the justice system. The cost to the community in lost lives and resources is a constant reminder that domestic violence is not a family affair, nor is it merely a private affair. It is a community affair demanding a community response.

CONCLUSION

Health care providers can play an important role in a coordinated community response to domestic violence by acting in ways that increase the safety of the victim and the children, supporting victims in making their own decisions about their lives, and holding perpetrators, not victims,

responsible for their domestic violence. Understanding domestic violence as an issue of abusive control of intimate relationships with health-shattering consequences is the first step to effective interventions.

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